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ABSTRACT

The practicum was designed to improve the multidisciplinary team (MDT) process for identifying seriously emotionally disturbed (SED) students within five elementary schools, with the primary goal of implementing a decision facilitation model in order to provide a more systematic approach to SED identification. Initially, inservice training was provided to 40 MDTs in order to improve their conceptual understanding of the SED identification process. During the 12-week implementation phase, a decision facilitation model was implemented which focused on MDT responsibilities, information gathering and documentation requirements, and specific SED eligibility criteria. Twenty of the originally inserviced MDTs completed a post-implementation evaluation instrument. Results suggested that inservice training efforts were successful in improving MDT members' understanding of the critical conceptual components and eligibility criteria found within the SED definition. The decision facilitation model was judged an improvement over previous identification procedures by a majority of respondents. Among concluding recommendations is an effort to improve the relationship between assessment and eligibility procedures and intervention strategies. (JW)

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PRACTICUM REPORT

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Ed.D. Program

Improving the Process for Identifying Seriously Emotionally Disturbed Students Utilizing a Decision Facilitation Model in Elementary Schools.

Thomas J. Craney

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Improving the Process for Identifying Seriously Emotionally Disturbed Students Utilizing a Decision Facilitation Model in Elementary Schools

by

Thomas J. Craney
Cluster XXI

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A Practicum I Report Presented to the Ed.D. Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

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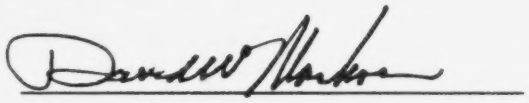
PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier: 

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This practicum report was submitted by Thomas J. Craney under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

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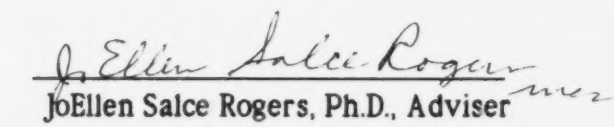

JoEllen Salce Rogers, Ph.D., Adviser

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The writer of this practicum report expresses his appreciation to the teachers, administrators, and other educators and individuals who served on multidisciplinary teams (MDT) and participated in the piloting of the Seriously Emotionally Disturbed (SED) decision facilitation model. To the students and parents touched by the practicum process, the writer extends his appreciation as well. For the opportunity to undertake the piloted program on such a wide scale, the writer thanks the Supervisor of Special Education and Psychological Services and the Area Director, without whose support the pilot would have remained an idea. Finally, the writer expresses his gratitude for the support and encouragement offered by his adviser, Nova University staff, and his fellow students.

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ABSTRACT

Improving the Process for Identifying Seriously Emotionally Disturbed Students Utilizing a Decision Facilitation Model in Elememtary Schools. Craney, Thomas J., 1987: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Emotional Disturbances/ Emotional Problems/Behavior Disorders/Identification/Handicap Identification/Labeling (of Persons)/Diagnostic Tests/Clinical Diagnosis/ Behavior Rating Scales/Behavior Patterns/ Operational (w) Definition/ Operational (w) Model/ Educational Models/Ecological (w) Emphasis/ Empirical (w) Emphasis

This practicum was designed to improve the multidisciplinary team (MDT) process for identifying Seriously Emotionally Disturbed (SED) students within five elementary schools. The primary goal was to implement a SED decision facilitation model in order to provide a more systematic approach to SED student identification by MDTs within a public school setting. The practicum also served as a pilot for possible decision making procedural changes to be implemented locally, system wide.

The writer identified procedural weaknesses in the system's SED decision making processes; developed a decision facilitation model and worksheet to assist MDTs in their focus with regard to MDT member responsibilities, information gathering and documentation requirements and specific SED eligibility criteria; inserviced school MDTs regarding pilot procedures and operationalization of the model; served as the pilot facilitator, monitored it's implementation, and developed and administered an evaluation component.

The results of the practicum were positive. Analysis of the evaluation data indicated that 9 out of 10 post-inservice/implementation MDT members were able to demonstrate their understanding of the critical aspects of the SED definition with regard to the eligibility criteria. MDT members were able to list the general areas from which pertinent SED decision making information is gained and the MDT members potentially responsible for the collection and/or presentation of the information. Eight out of 10 rated the model as an improvement over previous SED decision making practices with regard to "within-MDT consistency/reliability," "level of accountability," the model "overall," and consideration for the model's "adoption for use system wide." Recommendations and dissemination plans are presented.

CHAPTER I

INTRODUCTION

Community Description and Demographics

The geographical setting for the practicum is that of a rural/suburban county with an approximate population of 115,000. Land use statistics for the county (League of Women Voters, 1986) reveal that 74% of the land in the county is considered agrucultural/rural, 2% industrial/commercial, and 8% residential.

The county wide school district is headed by a seven member governor appointed Board of Education (BoE). The superintendent is the school district's chief administrator and also serves as the BoE's Secretary/Treasurer. The public school system consists of 24 elementary schools, 8 middle schools, 7 high schools, and 4 special schools (i.e. vocational-technical, special education), and serves over 24, 000 students in total.

The specific population targeted for this practicum consists of a public school "feeder system", which is comprised of a high school, into which two middle schools and five elementary schools feed. The high school is one of two high schools in the county's seat, a city with a population of approximately 33,600 (League of Women Voters, 1986). The elementary

and middle schools fall within an eight mile radius of the high school. The feeder system serves approximately 5,600 students and includes attendance areas drawing from rural, suburban and city areas.

Each of the eight schools comprising the targeted feeder system has a body of professionals responsible for addressing the needs of special students. These problem solving teams (locally referred to as Admission, Review and Dismissal [ARD] committees) consist of regular and special education teachers, administrators, guidance counselors, school psychologist and others, depending upon the specific needs of the student and the personnel resources available to the school. The multidisciplinary team (MDT) members within each school are responsible for carrying out state and local mandates as they apply to the decision making processes (i.e. identification, programming and placement) with regard to students suspected of having educationally relevant handicapping conditions. Although the local district refers to the MDTs as Admissions, Review and Dismissal (ARD) committees, with both acronyms referring to the same body of individuals, the more "literature apparent" MDT acronym will be used in this paper. The state and local mandates guiding the MDT's functioning are directly connected to a body of federal legislative measures know as the Education of the Handicapped Act (EHA), which includes PL 94-142 and supporting legislation. Specifically targeted within this practicum are those feeder system MDT members and procedures employed in the identification of students suspected of having a serious emotional disturbance (SED).

Work Setting and Role

As the school psychologist assigned to the aforementioned feeder system, this writer has MDT membership responsibilities in all eight schools.

In addition to the school level MDT responsibilities, this writer also serves as the school psychologist on an area-based MDT, responsible for level IV (self-contained special education program) programming and placement decisions, and, when appropriate, a district-based MDT with level V and VI decision making responsibilities (special facility, residential placement). The school psychologist is as EHA indicates, one of the qualified examiners (the others being psychologists outside the school system and psychiatrists) of students suspected of having a SED. After conducting an appropriate evaluation of the student the school psychologist is obliged to present relevant findings, in the form of a report, to the entire MDT. In addition to the school psychologist's report, other relevant information is presented and discussed by the MDT members, and through a process of consensus a determination is made regarding the presence of an educationally significant SED. Like the MDT process for other handicapping conditions, the team also has responsibility for programming and placement decisions. A very general outline of the SED identification process is presented in the school district's "Guidelines for Determining Serious Emotional Disturbance", and has recently been supplemented with a MDT discussion matrix, "Guide for ARD Discissions Concerning Serious Emotional Disturbance." (Appendix A and B respectively).

This writer has earned a Bachelor or Arts degree in psychology, a Master of Arts degree in school psychology and an Advanced Graduate Certificate in school psychology (program of study one year beyond the Master's level). This practicum is a requirement of a three year doctoral program in Early and Middle Childhood in which the writer is a second year student. This is the writer's fourth year of employment as a public school psychologist, and has been granted the School Psychologist II/Advanced Professional Certificate by the State Board of Education. Related professional

experiences include six years of clinical experience as a technician on inpatient psychiatric units in military and private hospital settings.

CHAPTER II

Study of the Problem

Description of the Problem Situation

A significant portion of the problems faced by MDT members during the SED decision making process stem directly from the ambiguity of PL 94-142 itself. Consequently state and local interpretations, and subsequent implementation of the law, often remain equally ambiguous. The responsibility for the "operationalization" of the EHA mandates (the spirit of the law, if you will) lies on the shoulders of the state, and local education agencies (LEAs).

Within this practicum's targeted school district there exists no systematic or well defined method of addressing the critical definitional aspects of SED as described in the system's "Guidelines for Determining Serious Emotional Disturbance". This is, in part, the result of the state's having "lifted" the EHA's definition of SED directly from that body of legislation. The school district's lack of a systematic plan and specified procedures aimed at addressing the critical issues, opens for question the integrity and consistency with which the MDTs arrive at their decisions regarding SED. The lack of an operationalized definition and systematic approach to SED identification results in the increased chance, and liklihood, of decision related inconsistencies (i.e., reliability and accountability)

between individual MDT members of the same team, as well as MDTs of different individual schools within the district.

The systematic evaluation and objective quantification of the critical aspects of the existing SED definition would enhance operationalization efforts (Gresham, 1985). In a contrasting tack, efforts have been undertaken to address the actual content (and spirit) of the specific federal legislation guiding the SED decision making process. But while the merits of the law alteration approach are being debated, the long range nature of such an effort does little to resolve the problems associated with the present state of affairs. Advances in behavioral assessment have improved the process of quantifying behavioral characteristics thought to be concommitant with SED, yet significant controversies persist in the areas of personality and socio-emotional assessment (Goh & Fuller, 1983). It would appear then, that a systematic approach to the SED decision making process would offer a practical and more immediate solution to the problems faced by MDTs. The potential for inconsistencies within the MDT's decision making processes can be miniimized through the implementation of systematic guidelines, in effect, a SED decision facilitation model.

Briefly stated then the problem is that while very general guidelines exist, there are no systematic procedures in place for the MDTs to follow while specifically addressing the eligibility criteria in the SED definition when presented with a student suspected of having a SED.

Problem Documentation

Evidence to support that other states and LEAs are faced with similar SED procedural issues is abundant within the literature (see the review below), particularly as related to the quantification of the critical aspects of

the SED definition and systematization of the decision making process. More immediate and local concerns have been raised by administrative personnel within this writer's school district. Through an on-going dialogue with supervisory and administrative personnel at the district and school levels, it has become apparent that all have recognized, at one level or another, the ambiguities of the state law, the inherrent limitations in the LEA's interpretation of the law, and the potential for the MDT's irregular execution of the SED decision making process. Administrative and supervisory personnel not only recognize the limitations of the existing "Guidelines for Determining Serious Emotional Disturbance", but welcome the evaluation of the existing process with the hope that more systematic, consistent and effective processes may be placed into practice.

In addition to administrative personnel, individual MDT members from all schools served, have over the last several years brought to the attention of this psychologist, concerns regarding the lack of specificity and consistency as related to the SED decision making process. Specific concerns were often related to issues of differential determinations between schools within the system, inconsistancies in performance within MDTs, and the accountability of MDT members involved in the "less than clearly guided" SED decision making process. In light of the recent increase in the questioning of MDT decisions at the hearing and judicial levels (Staff,1986), and the sheer number of decisions needing to be made by the MDTs (Special Education Management System's records [Sept.1986] indicate that approximately 14% of the local district's student population receives some level of special education service, and .75% of the total population identified as SED) the team member's concerns appear warranted. Personal experience and first hand observations also serve as evidence of the procedural

difficulties. As a school psychologist with MDT responsibilities in five elementary schools, two middle schools, a high school, area and district proceedings, this writer has developed an increasing awareness of the limitations of the existing SED decision making process. While the implementation of any procedure will be influenced by personnel and contextual factors (Fleming & Fleming, 1983), the potential for inconsistencies within the present process can be reduced significantly through systematic structuring and implementation of a SED decision facilitation model.

A recent newspaper article (Joy, 1987) has indiciated that concerns are being expressed by community groups regarding the disproportionate identification of a specific population of students as educationally handicapped. The SED population would appear to be of particular interest. Sited in the newspaper article, a recently released BoE evaluation of minority student participation and achievement in county educational programs supported the claims. The BoE report included recommendations for improved equity but did not target the special education (i.e. SED) identification processes specifically.

Analysis of Causes

The causes of this very real SED decision making problem are numerous. In a very general sense it is the definitional ambiguity and lack of operationalization found within the EHA legislation (Bower, 1982) rearding the SED handicapping condition, and it's determination specifically, that serves as the foundation of the problem. Consequently, the responsibility for EHA interpretive elaboration cascades onto the shoulders of state legislators and/or state and local eductional agencies. As the

literature indicates (Knoff, 1986), individual states have opted to address the issue from varying perspectives or, as in the case of this writer's situation, deferred action on the problem of operationalization to the LEAs by the unadulterated adoption of EHA's definition. Although problem solving efforts are being undertaken at the state level (i.e. state education agencies, professional organizations, and groups of LEAs) it becomes the responsibility of individual LEAs to perscribe methods and procedures in the execution of their state's mandates. Within this writers system, as well as other LEAs within the state, significant weaknesses have become apparent in the general guidelines set forth by the system and utilized by the MDTs in their decision making processes.

The subjective nature of many of the procedures used to evaluate individuals suspected of having a SED makes the objective quantification of SED conditions and their corresponding characteristics very difficult, at best. The lack of a concensus and empirical validation of the behavioral correlates of SED (Boyle & Jones, 1985), often useful when behavioral assessment procedures are employed in the evaluation of individuals suspected of having a SED, also serve as impediments to more refined interpretations of the law. In an issue clearly related to definition and measurement, the lack of clearly defined SED prevalence indicies found with the general population, or a more specific "norm" group (i.e. the school district population) have significant impact on the subsequent undertakings of MDTs.

Review of the Literature

Overview

Local educational agencies (LEAs) and state departments of education have, since the passage of PL 94-142 over a decade ago, been mandated to

enact certain special education laws and implement specific policies in order to address the needs of educationally handicapped students. The purpose of this federal legislative measure, often referred to as the Education of the Handicapped Act or EHA, is to provide handicapped children access to educational opportunities otherwise unavailable to them (Slenkovich, 1985).

There are considerable variations in the reinterpreted laws from state to state, and within the LEA's interpretation of the state's, sometimes modified, interpretation of EHA. However, there is also considerable confusion and discussion regarding the nature of Congress' intent when the EHA was brought into law. Unfortunately, litigation and court decisions have often been the mechanism whereby concerns have been addressed.

Although there is continuing debate regarding the appropriateness of, or perhaps even questioning the existence of, specific educationally impacting handicapping conditions, public education practitioners are legally obliged to implement the spirit of the EHA by operationalizing state interpreted laws, codes and regulations. The handicapping category or classification referred to in PL 94-142 as "serious emotional disturbance" (SED) is perhaps, of the ten handicapping designations, the most controversial and debated. While some argue that educators have no qualifications for involving themselves in the "mental health business", state departments of education and LEAs are mandated to implement (although some chose to augment the federal directive) the EHA charge, and specifically, address the issue of emotional disturbance as it applies to it's educational consequences.

Individual states have interpreted EHA in a variety of different fashions in their development and refining of their respective codes and laws. Seemingly minor changes in terminology have resulted in wide spread

controversy, in which questions regarding ethical, ideological, philosophical, theoretical, conceptual and practical (this is not an exhaustive documentation) issues are raised. Consequently, struggles involving intent, semantic interpretation, condition prevalence or incidence, empirical validation of such conditions, appropriateness of assessment methodologies, programming and intervention, accountability and a host of others have ensued. While there has been significant progress made in the understanding of the SED issue and in the operationalization of it's related tasks over the past decade, there is increasing pressure for educators to systematically address the pertinent issues and work toward resolving identified concerns.

Definition Matters

The federal definition of "emotional disturbance" put forth in PL 94-142 is Eli Bower's 1957 definition, with some modifications (Bower, 1982). The educational institutions of this country are striving to understand, clarify and operationalize the mandates regarding their duties in the education of SED students, and handicapped students in general (California Association of School Psychologists [CASP], 1984 a&b; Knoff, 1986; Maryland State Department of Education [MSDE], 1984; Montgomery County Public Schools [MCPS], 1986). Yet Bower (1982) himself claims that modifications in his original definition which made their way to the EHA, resulted in damage to the integrity of the research and conceptual base from which the definition was drawn. Therefore, even in those states where the federal definition was virtually lifted from it's PL 94-142 context (MSDE, 1984; Knoff, 1986) it has been compromised.

The PL 94-142 definition combined the clinical, intra-psychic concept of emotional deviance with the school-related behavioral one. This interpretation, Bower (1982) argues, limits the schools' ability to act as a primary prevention institution and has extensive operational complications as related to assessment. While Bower is aware of the historical, social and economic influences on public policy generation, he insists that these factors cannot dictate it's direction. Social scientists must work cooperatively with policy makers in order to bridge the practical/conceptual gap now prevalent. The paradox of EHA has been recognized by others as well. Forness, Sinclair and Russell (1984) feel that the paradox of EHA is that it formalizes rather questionable diagnostic criteria for each handicapping category or classification, including SED, while at the same time insisting on individualization with regard to programming. Again the focus is seen on identification, post hoc, and not on prevention. The criteria concept, while useful in the identification phase, has few practical implications for subsequent intervention. Eligibility and the resulting delivery of service may be entirely based upon an "all or nothing" criteria approach. As alternative classification models have been explored, questions have been raised regarding the adequacy of the EHA definition itself. In fact, parent lobbying efforts were successful in having the "autism" designation which fell under the SED category, moved to the "other health impaired" category (Forness et al., 1984), perhaps viewed as a much "cleaner" and less stigmatized classification.

The relationship between terminology and meaning, in an operational sense, is inextricable. The definitional ambiguity found within EHA as it pertains to emotional disturbance, lends little insight into the procedures used for assessment, identification and program planning (Gresham, 1985).

Efforts were undertaken on a national level to investigate the merits of altering the PL 94-142 definition of SED by replacing the existing SED terminology with the increasingly popular "behavior disorder" (BD) terminology. Some of the reasons for pursuing the change in the definition have been tied to the "stigma" attached to the SED label as opposed to the BD label. Labeling children emotionally disturbed has been shown to have clearly negative associations for teachers, parents and students; a situation which exists to a lesser degree with the BD designation (Wood, 1985). Operationally however, Wood found that professionals within the field saw the SED/BD combinatorial definition as the most desirable. It was also argued, and supported by the National Association of School Psychologists (NASP), that the BD definitional reinterpretation would help with the shift from the medical and psychodynamic models to a more objective and empirically based educationally relevant model (Dwyer, 1985).

Although the BD terminology does not exist in the EHA definition as it stands, and BD is not considered a handicapping condition within this context, many states and LEAs have interpreted the SED definition to include BD, or perhaps more accurately, the BD interpretive definition includes SED (Knoff, 1986). This obvious and relatively consistent grassroots movement became most apparent when the results became available for the Congressionally authorized study undertaken to determine what it was that the states were doing in terms of the definitional interpretation and operationalization of SED, with particular emphasis on the possible effects of a change from SED to BD (Knoff, 1986). The results indicated that 27 states were using the SED or "emotionally handicapped" (EH) label which was similar to the EHA definition. Twelve states used the BD or "behaviorally impaired" (BI) label. Whereas four states used a mixed BD/SED label, and

five states utilized a social and emotional maladjustment or personal and social adjustment label, three states were reported to be functioning in a non-catagorical model. The label-less model tends to focus on the level of service needed by a student not their classification(Knoff, 1986). While the Congressional study's findings did not result in an alteration of the federal definition (Dwyer, 1985), the gains in educational professionals' perspective and insight have been innumerable.

In an effort to help with the reinterpretation of SED, models for comprehensive and practically useful definitions have been proposed. Gresham (1985) suggests that a BD definition (notice it's not SED) would include: (a) specification of excesses, deficits and/or situational inappropriateness of behavior in operational terms; (b) specification of objective features of behavior and it's multiple dimensions, such as frequency, duration, intensity, etc.; (c) specification of the behavioral system or systems through which excesses and deficits are expressed; (d) demonstration of the excesses and/or deficits across situations; (e) occurrence of excesses or deficits over time; (f) agreement upon the occurrence of excesses, deficits or situational inappropriateness of behavior using multiple methods of assessment; and, (g) the continuation of excesses, deficits and/or situational inappropriateness of behavior at an unacceptable level subsequent to a school-based intervention. Models for fine tuning the SED/BD definition are useful in the making conceptual shifts necessary for an appropriate problem solving undertaking, yet they are merely a point of departure for the endeavor. The empirical determination of SED/BD within the general population has obvious implications for the classification and assessment methodologies employed by practitioners.

SED/BD Prevalence

The lack of a clear definition in conjunction with the lack of accurate prevalence estimates serves to further complicate the already difficult identification decision making process. Kauffman (1984) describes the task of identifying social deviance as "risky business". Prevalence estimates have ranged from a very conservative 1.2 to 2% of the school age population, to what others have found to be a more realistic prevalence estimate of 3 to 6% (Cullinan, Epstein and Kauffman, 1984). Long (1983) presents findings at the opposite extreme, with the prevalence of school children with emotional problems serious enough to warrant special help as high as 8 to 14%. As records would indicate (Special Education Management System) the local school district's interpretation of the law's SED definition is, perhaps rightly so, considering the seriousness of the "labeling", a conservative one.

The U.S. Department of Education has reported that SED children represent the forth largest of the ten categories of handicapping conditions served within the public schools, with nearly 350,000 children and adolescents so identified (Forness et al., 1984; Cullinan et al., 1984). Statistics from the Bureau of Education for the Handicapped for the 78/79 school year indicated that the incidence of SED/BD identification was only .54%, which is well below the relatively conservative but consistently quoted 2% expected incidence rate (Gresham, 1985). Yet at the service level, Forness et al. (1984) reports that 42% of the identified SED/BD students are served in regular classrooms, while 44% are served in special education classes. Slightly over 10% of the identified students are served in residential and hospital settings. Ethical concerns regarding identification and over-identification have surfaced repeatedly. Paul (1985a) takes the position that SED/BD may be viewed as cultural byproducts. In order to justify the

process of identification and intervention increased contextual research is necessary. Paul suggests that the current system serves to identify already vulnerable individuals and make them perceptibly more vulnerable.

Research findings regarding concerns about the over-labeling of children as SED/BD are indicating that the concerns are unfounded. Generally, SED/BD children are under-detected and under-served in the public school systems. Moreover, students of poor school districts or districts with a high proportion of minorities are served least adequately, rather than the misconception of being over-detected and over-labeled (Long & McQueen, 1984). Social, political and economic trends in this country, in conjunction with specific unique conditions within local school districts, directly impacts the detection and treatment of SED/BD children (Long, 1983).

Classification Systems

In his historical analysis of the issue of SED/BD and classification, as it applies to the duties of the public school system, Paul (1985b) points out that of the handicapping categories described in EHA the field of SED/BD perhaps has the most shallow pedagogical roots, yet it has the deepest philosophical and psychological roots. Although our personal theoretical perspectives guide our behavior, they are strongly influenced by the environmental climate, cultural and community perspectives, our ability to empirically validate our beliefs and "popular" support. The impact of "available" interventions and the prevailing system of classification cannot be over-estimated when examining the reality of the SED/BD decision making processes.

Trends in the identification and classification of children with SED/BD have been shown to shift over the years, particularly as a result of the EHA. The medical and psychodynamic theoretical orientations gave way to more behavioral orientations. More recently, narrow behavioral perspectives have given way to sociological and development/ecological perspectives, which have had direct impact on the practices within the public school settings (Paul, 1985). Numerous systematic undertakings addressing conceptual and operational issues have been documented (CASP, 1984 a&b; Lenawee Intermediate School District, 1986; MSDE, 1984a; MCPS, 1986). The SED Task Force of CASP in coordination with other sub-task groups sought to develop an Educational Diagnostic Manual for the SED/BD student. The resulting draft serves to operationalize the SED/BD category and correlates the developed system with the extensively utilized Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) (American Psychiatric Association, 1980).

Knoff (1985b) has briefly described four of the most frequently used classification systems with SED/BD children. Obviously, the educational classification system of EHA is used, and perhaps abused, extensively, and has only been in existence for a decade. Because this was a political and legislative undertaking, the absence of clarity and operationalization, as we have seen thus far, ultimately serves to weaken the system. The psychiatric classification system, utilizing the DSM III, is quite comprehensive in it's description of specific childhood disorders, and lists the criteria or manifest characteristics for the disorder, the degree to which they need to be in evidence, and the length of time they must be present. Some see the DSM III system as a decided improvement in the classification of mental disorders (Sattler, 1983), particularly as it applies to the school

psychologist's role in the administration of intellectual and achievement tests (although not personality assessment instruments) central to the assessment and identification process, of selected disorders, described in DSM III. While the DSM III system specifically addresses many of the weaknesses of the educational classification system (i.e. the subjective definitional aspects, such as; "marked extent", "long period of time", "inappropriate feelings") there have been serious questions raised regarding the reliability, validity and utility of the system (Slenkovich, 1983).

The DSM III system's limitations have been described as being related to the medical model of abnormal behavior, and the flaws inherent in this conceptual orientation. Gresham (1985) indicates that there has been relatively poor reliability and validity demonstrated for specific disorders. The DSM III system relies upon the subjective judgment of professionals in many instances, while empirically-derived systems utilize more objective and statistically sound approaches for identifying behavioral patterns. These empirically-based systems tend to demonstrate increased reliability and validity over the clinically-derived systems (Gresham, 1985). Other multiaxial and multidimensional proposals for the classification and typology of children's SED/BD have been formulated and increasingly included empirically verified techniques in defining syndromes, similar to those described in DSM III (McDermott, 1983). Without the empirical underpinnings, clinically-derived systems lack the relevance between the descriptive designation and subsequent intervention and treatment (Gresham, 1985).

As Knoff (1985b) reports, the Group for the Advancement of Psychiatry (GAP) had proposed an alternative classification system for SED/BD children nearly 20 years ago, with a revised system having been in

place for more than 10 years. Although this is not an extensively utilized system, it offers a sound philosophical and conceptual base from which school psychologists may operate. The GAP system is particularly sensitive to developmental variables and characteristics within children's socio-emotional domains, as well as environmental and situational factors, which are kept in perspective.

Empirically-derived classification systems have arisen out of more sophisticated statistical and data analysis capabilities as applied to the behavioral assessment of children. Although validation studies are needed to determine the effectiveness of these approaches when compared with more traditional psychometric methods, the empirically-based system may provide the most defensible and useful of systems. As one might expect, the implications that an empirically-based system has for assessment practices and subsequent intervention and progress monitoring undertakings are both numerous and far reaching. The information gathering assessment is the psychometric root to this type of classification system.

Trends in Assessment

The analysis of the conceptual and theoretical basis of personality assessment and the corresponding system of classification, can shed light on the attitudes and activities of those who work within the system under study. Knoff (1985a) has briefly put forth a review of eight theoretical orientations and/or models frequently used by professionals to explain children and adolescent personality and behavioral patterns. The operational consequences of following a particular school of thought are dramatic and pervasive, and should be fully understood by the responsible practitioner. It has been found that the "professional judgment", while being

encouraged in the matters and areas that are not addressed specifically by "standards" or guidelines, of school psychologists and other practitioners are frequently guided by informal or intuitive "personal theories" regarding behavior (Barnett, 1986). Yet these professionals, for legal, ethical and professional reasons must be able to adequately describe their personal models with regard to the recognized standards. Documents like the Standards for Educational and Psychological Testing (American Psychological Association, 1985), that aid in the development of personal and professional standards, have become increasingly important to the practitioner.

A conceptual model for the assessment of SED/BD has been proposed by Gresham (1985). The model operationalizes the assessment process by translating the conceptualizations through the use of principles, which include: the problem solving and functional analysis of the findings through multiple operationalism (validity) and generalizability (validity and reliability of the relationship between instruments and other settings, as well as the social validity of the identified behavioral deviation). Social behavior assessment is also effective in contributing valuable information to both classification and programming efforts (Stumme, Gresham, Scott, 1982). After a through review of the practices in the assessment of children's personality, Barnett and Zucker (1985) also recommend the multidimensional assessment approach. Suggestions for assessing the suitability of existing measures of SED/BD in childhood have been made by Boyle and Jones (1985). Their evaluative model includes the means for assessing the acceptability, applicability, procedural adequacy, reliability and validity of a number of empirically-based instruments and rating scales.

Historically, projective techniques, especially figure drawings and sentence completion devices, were the most frequently used instruments for

personality assessment by school psychologists (Goh & Fuller, 1983). Objective personality tests and rating scales have been utilized to a lesser extent, perhaps due to their underlying theoretical orientations, the training of field professionals and the short history of behavioral assessment in general. However, a shift in emphasis, from the more subjective to the more objective, is under way and is expected to continue. School psychologists and other practitioners have had difficulty in developing appropriate means of behavioral assessment due to definitional inconsistencies and real and perceived limitations in knowledge and skill in the conduction of SED/BD assessments. For example, although research has indicated that school psychologist's rely upon the analysis of WISC-R profiles for the diagnosis of an emotional impairment, the validity of such a procedure has not been demonstrated (Clarizio & Veres, 1983). The assessment and intervention duties of the school psychologist and other examining professionals have been directly affected by the Hatch Amendment to the General Educational Provisions Act. Informed consent may be legally interpreted to include an understanding of the validity issues and relationship between assessment instruments and subsequent educational interventions (Huberty, 1985).

The increasing importance of behavioral assessment and direct observation techniques serves to bridge the gap between practices, old and new (Alessi & Kaye, 1983). As with all movements, existing practices are often used as the foundation for developing new practices. Quay (1983) has drawn parallels between the empirically-derived dimensions of the Revised Behavior Problem Checklist (RBPC) and several of the descriptive categories found within the DSM III. Unlike the clinically-derived system, the behavioral ratings approach allows parents, teachers and others to organize their observations of children in a systematic, reliable and valid fashion.

Multidisciplinary Teams and Decision Making

There have been conflicting reports of the type of information actually used by professionals on the MDT in making a SED/BD determination. Research suggests (Smith, Frank & Snider, 1984) that school psychologists and teachers agree on the type of data required for making an appropriate SED/BD classification decision, however, actual examination of SED/BD identified student records suggests a lack of preferred/desired data. McGinnis, Kiraly and Smith (1984) found that descriptions of the student's behavior (without supporting evidence) and accounts of family/environmental history were most influential on the decisions of MDTs.

There has been discussion regarding the problems associated with role and functioning of the MDT in the school systems, with concerns revolving around role ambiguity and confusion regarding responsibility for decisions. The justification of the MDT has been questioned and it is clear that additional research is needed with a focus on the organizational characteristics of the schools and the policies which guide them (Yoshida, 1983). Existing research suggests however, that the product of increased decision making effectiveness can be the result of a MDT. The MDT, by law, has the purpose of effectively using the resources of the individual team members, and as Ableson and Woodman (1983) have pointed out, increased involvement in the decision making process promotes commitment to the outcome and increases the probability of success. But while the law mandates the parent's involvement on the MDT, findings have described the obstacles to effective parental participation in the processes of identification and in program and placement decisions (Forness et al., 1984).

The time, human resources and level of skill development within the MDT vary significantly. Yet through organizational self evaluation in the areas of efficient use of available time, developing the knowledge and skills base of team members, assignment of available personnel resources and developing strategies for reducing team member stress, the MDT is destined to increase it's productivity and overall effectiveness (Fleming & Fleming, 1983).

Eligibility and Service

Inconsistencies have been documented in the interpretation of eligible students for SED/BD classification because of pressures from sources external to the system, availability of services, short duration of behavior and residential placements made because their family situations were "awful" (Forness et al., 1984). Identification procedures must be sensitive to the suffering of or effects of SED/BD student's behaviors on themselves and those around them. And as Kauffman (1984) suggests, the consequences of identification versus non-identification must be weighed, yet to do so effectively, research must be conducted regarding our current educational practices and interventions. The lack of information regarding the effectiveness of interventions for the SED/BD student only serves to make the argument for identification a weak one at best (Kauffman, 1984).

Forness et al. (1984) argue that the current definition of SED under EHA forces the schools to document an intra-psychic problem in order to find a BD student eligible for special services. Here the emphasis is on an underlying emotional disorder rather than the behavior of the student, which is, as we have seen, counter to the prevailing practices in the field of special education. Ultimately, the eligibility decision process is determined

by how MDTs resolve issues related to the problematic definition of SED and/or BD under existing federal and state laws, and the problem of differential diagnosis between students who evidence a SED/BD and those students with other handicapping conditions or maladjustments. The non-catagorical approach to special education is one possible alternative. It is designed to specifically address the instructional needs of the student primarily in terms of student/teacher ratios, individualized educational programs, and determining the level of motivational support or external incentives that is required (Forness et al., 1984).

The concerns related to the delivery of service are best understood when the influence of the decision context(s) is clear when determining a student's eligibility for special education services. A political context may influence the actual interpretation of deviance, particularly when viewed from the civil rights perspective for example. From a professional context, special educators view themselves, at times, as the saviors of the children, which would suggest the need for a closer examination of the effects of our "best of intentions" interventions. Within the research and technological contexts, empirical investigations will aid in resolving some of the ethical and moral dilemmas. An ineffective coordination between the educational system and other health care delivery systems is blamed for the under-service of SED/BD students (Forness et al., 1984). But it is also argued (Slenkovich, 1985) that public educational institutions are not in the business of "curing" SED/BD students, but rather supporting students so they have been given an opportunity to benefit from the instructional and educational experience. EHA was never intended to "fix" students or even maximize their potentials. An "equal" educational opportunity, for anyone, handicapped or not, is an unworkable standard requiring impossible

measures and comparisons (Slenkovich, 1985).

CHAPTER III

Anticipated Outcomes and Evaluation Instruments

Goals and Expectations

The goal of this practicum was to introduce and implement a SED decision facilitation model in order to provide a more systematic approach to the process of SED student identification by MDTs within a public school setting. Inservice training was to be provided to MDTs in order to improve their conceptual understanding of the SED identification process. An SED decision facilitation model was to be provided to help to assure that MDTs more closely adhered to the SED definition's conceptual underpinnings, effectively utilized information and personnel resources, and improved SED decision making consistency/reliability and accountability.

Objectives and Evaluation

Following the inservice session and 10 to 12 week period of implementation, and when provided with the complete SED definition and brief conceptual descriptions (see Appendix F for the evaluation form), individual MDT members were asked to demonstrate their understanding of the critical aspects of the SED definition (i.e., the concepts of "condition," "characteristics," "long period of time," "marked degree," "adversely affect" educational performance, "social maladjustment") by correctly circling the

terms and matching them with conceptual descriptions, at the 80% level of accuracy.

The individual MDT members were asked to list, at the 80% level of accuracy, the general areas from which pertinent SED decision making information is gained. In addition, the individual MDT members were asked to list, at the 80% level of accuracy, the team members potentially responsible for the collection and/or presentation of necessary and relevant SED decision making information.

It was predicted that at the conclusion of the 12 week implementation phase, 8 out of 10 indivudual MDT members would rate the SED decision facilitation model as an improvement over previous decision making methods and procedures. Using a three choice scale (improvement--remains the same--no improvement) subjective ratings were obtained in the following areas:

Ease of utilization...
Within-MDT decision making consistency/reliability...
Between-MDTs decision making consistency/reliability...
Level of accountability...
Overall rating of the piloted model...
Adoption of the piloted model for use system wide...

Outcome Presentation

The analysis of the post implementation assessment results are divided into two major components. The criterion levels, 80% for the objective component and 8 out of 10 for the subjective component, were set prior to implementation. Accuracy levels , in the form of proportional fractions, have been compliled and presented for the MDT members assessed, and reflect the results of individual objectives being measured. The findings are graphically represented in order to facilitate interpretation.

The MDT member's subjective ratings have been tabulated for each of the posed questions and are presented in the form of proportional fractions as well. The subjective ratings results are also presented graphically.

CHAPTER IV

Solution Strategy

Discussion and Evaluation of Possible Solutions

The refinement and improvement of the SED decision making process has, as indicated within the literature reviewed, been addressed from numerous prespecitves and at many levels. The scope of these endeavors range form organized national efforts to more idiosyncratic and individualistic undertakings. In an attempt to present these efforts in a hierarchical fashion, potential solutions to the SED identification problem will be discussed briefly.

Efforts have been undertaken at the national level with intentions that are primarily two-fold: (a) to determine the intent of the federal legislation such that changes in it's language, and subsequent operationalization, would reflect the corresponding clarification; and (b) to reinterpret or alter the federal legislation to "fit" the more operationalized SED/BD decision making practices already in place. Bower (1982) recognized the operational complications of the SED defintion as adopted by Congress and argued that the theoretical and conceptual base from which the definition had been drawn had been compromised. But, efforts aimed at clarifying the federal legislation have, thus far, proven unsucessful.

In addition to definition clarification, efforts were undertaken to reinterpret the law to include, among others, a BD component. Individual states (Wood, et al., 1985) have taken it upon themselves to interpret and garnish the federal law with a BD component (Knoff, 1986), yet attempts to do the same at the national level have failed (Dwyer, 1985).

Knoff (1986) has indicated that 16 states have made interpretive leaps from the federal SED definition to a defintion that combines SED and BD, or a definition that subsumes SED under the more broad BD classification heading. Twenty-seven of the remaining states continue to use the SED definition and face the task of operationalization. Where the probability of state level legislative reinterpretation of the SED law is minimal (i.e., this writer's state), state and local agencies and organizations have attempted definition clarification and operationalization (CASP, 1984a&b; MSDE, 1984a; MCPS, 1986).

The undertakings aimed at the operationalization of the SED decision making process state wide are of a scope beyond that of this practicum. However, such efforts are worthwhile and, as a result of the cooperation of the state's department of eduction and the state's school psychologists association, are being undertaken at his time as a long range goal, by a committee of school psychologists, of which this writer is a part. The efforts at the state level must, within the scope of their investigation and proposed solution, address the more global issues (i.e., relationship between identification and intervention, prevention) facing SED decision making clarification and operationalization efforts. Issues with regard to assessment, classification and prevalence are among the most challenging. For example, assessment practices are often tied to theoretical models and conceptual assumptions (Knoff, 1985a) that have direct and significant impact on

subsequent classification and prevalence estimates. Trends in the identification and classification of SED/BD students have been toward more behavioral, sociological, development/ecological approaches, which is a departure from the long held medical and psychodynamic orientations (Paul, 1985).

Description and Justification of Solution Selected

Identified procedural weaknesses within this writer's school district, and the feeder system specifically, were within the scope of this of this practicum and are expected to serve as the framework for more ambitious undertakings (i.e., system and state wide efforts). The SED decision making process is complex and requires the collection and organization of pertinet information, discussion and action upon the data by MDT members. A model that facilitated the decision making process and supplemented the existing guidelines and frame of reference was developed and piloted as a solution to a locally recognized problem.

The solution to the school district's SED decision making problem piloted within this practicum is eclectic in orientation. It drew upon the findings within the literature and attempted to weave improvements into the fabric of the existing processes. Some agreement has been reached regarding the type of data required for making appropriate SED decisions (Smith et al., 1984), and the LEA's recent introduction of the "Guide for ARD Discussions Concerning Serious Emotional Disturbance" (Appendix B) serves to minimize the use of undocumented and/or inappropriate data, referred to by McGuinis et al. (1984) in the literature. Like Gresham's (1985) conceptual assessment model for BD, the piloted decision facilitation model delineates the critical components (i.e., criteria) of the SED definition and encourages

the more through use of aviailabe information resources for the purposes of SED identification and classification. Unlike the Gresham model however, an elaborate attempt was not made to assure that assessment, identification and classification data were pertinent to the planning of educational interventions. Although considered by this writer to be a worthwhile pursuit, the practicum's focus was restricted to SED definition operationalization.

In Slenkovich's presentation (1985) and book (1983) describing the legal guidelines for determing eligibility, the SED definition was reviewed with particular emphasis on it's critical components or eligibility criteria. Although Slenkovich's perspective is a legal one (as a defense attorney she supports her argument with judicial rulings) it may well prove to be the most "system accepted" approach to the problem. The fact is, many "final" SED decisions are being made by hearing officers and the judicial system and not educators and MDTs. The identified weaknesses found within the existing SED decision making processes (i.e., ones of consistency/reliability and accountability) were to be minimized through the implementation of a decision facilitaion model that incorporated, into existing procedures, an analysis of the critical components of the SED definition .

The critical components of the SED definition are concepts upon which resulting decisions rest. In a review and discussion of the pertinent and available data (using the existing Guide for ARD Discussions Concerning SED--Appendix B) the MDT must document the presence of a "condition," exhibiting "characteristics" over a "long period" of time, and to a "marked degree," which "adversely affects" educational performance, not a result of a "social maladjustment." Many of the inconsistencies noted within the existing processes result form less systematic approaches of addressing these

critcial components. The purpose of the inservice training and introduction of the Serious Emotional Disturbance (SED) Decision Facilitation Worksheet (Appendix C) was to enable MDTs, with improved reliability and accountability, at least, to systematically address and document the SED decision making process.

Implementation Plan

Final approval for the piloting of the practicum within the writer's feeder system was obtained from the Supervisor of Special Education and Psychological Services and the Area Director, following the proposal's approval from the writer's practicum advisor and the director of practicums. During scheduled MDT meetings, in each of the eight feeder system schools, this writer provided inservice training to available team members regarding the descision facilitation process. In an overview of the decision making task, the SED defintion was reviewed, with particular emphasis on the critical components and their conceptual interpretation (Appendix D). Weaknesses within the existing procedures were discussed after which the SED decision facilitation worksheet was introduced and offered as a solution to identified procedural limitations. The implementation of the worksheet was discussed in light of the data collection and analysis processes already in place (Appencices A & B). In addition, the "educational impact" documentation component of the worksheet was discussed, with parallels drawn regarding similar system prescribed procedures involving other handicapping conditions (i.e., severe discrepancy formula used for establishing learning disability eligability).

Inservice training was provided by this writer to MDTs (see Appendix E for inservice outline) within the first 2 weeks of the implementation

period, after which the MDTs implemented the SED decision facilitation model for 10 to 12 weeks. The MDT chairperson notified this writer of the pending referrals with regard to students suspected of having a SED, and the writer, serving as the school psychologist and pilot program facilitator, made a commitment to attend a minimum of 90% of the meetings. While it was difficult to predict the number of MDT meetings that would involve SED decision making, this writer was, upon notification, able to attend 100% of the scheduled meetings. In addition to anecdotal records kept by this writer during actual meetings, follow up meetings (at approximately 4 and 8 weeks) were scheduled with each of the schools' MDTs in order to address needs (i.e., additional inservicing) and/or concerns (i.e., procedural execution). Through responsive consultation on an "as needed" basis, this writer was prepared to respond to MDTs more immediate concerns. At the conclusion of the 12 week implemnation phase, objective and subjective measures were obtained from participating MDT members and are reported in the final chapter of this report and serve to document the piloted model's effectiveness in attaining proposed objectives. The specific practicum calendar and implementation time table is presented in Appendix F.

CHAPTER V

Results, Conclusions and Recommendations

Results

A total of 40 MDT members were inserviced regarding the utilization of the SED decision facilitation model. During the 12 week implementation phase, the decision facilitation model was utilized by MDTs a total of 9 times, with 5 of the 8 individual schools participating in the model's actual utilization. Twenty of the originally inserviced MDT population completed the post-implementation evaluation instrument (n-20), yielding a 50% attrition rate among those participating in the inservice training initially.

Results from the objective portion of the evaluation instrument (see Figure 1) indicate that 9 out of 10 evaluation respondents achieved an 80% level of accuracy, or greater, when asked to demonstrate their understanding of the SED definition and the decision facilitation model by identifying the critical conceptual components and matching them with the correct corresponding description. When asked to list the general areas from which pertinent SED decision making information is gained, 8.5 out of 10 respondents achieved an accuracy level of 80% or greater. Seven out of 10 respondents achieved an accuracy level of 80% or greater when asked to list

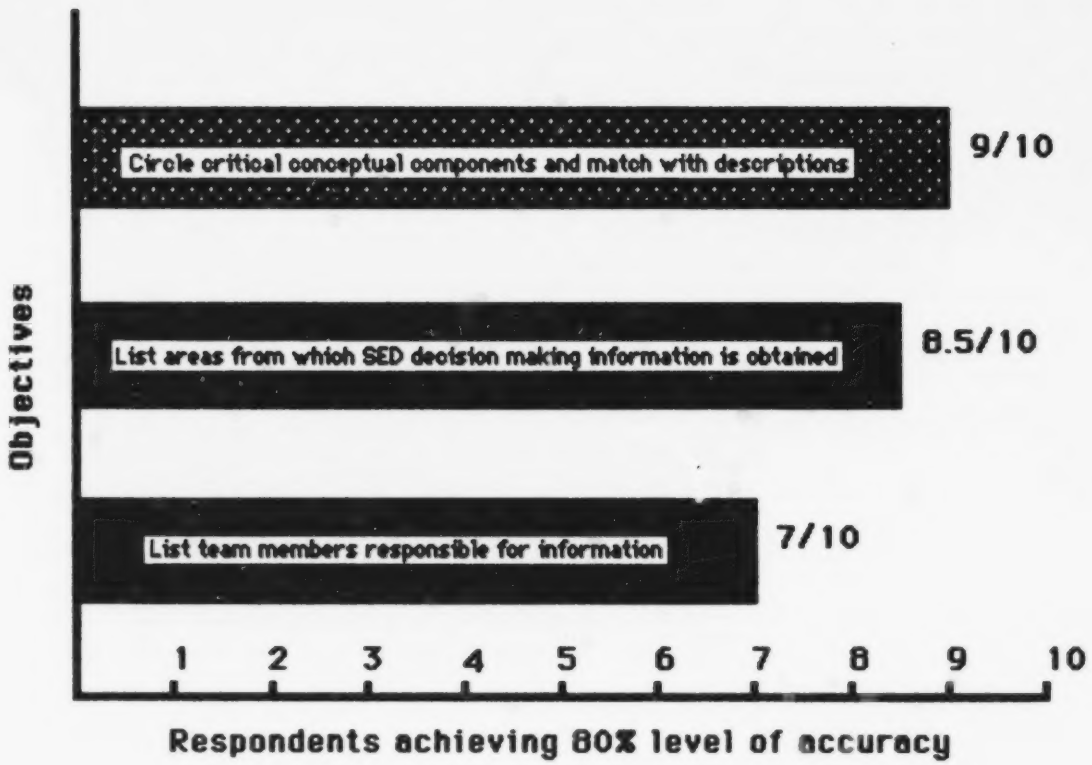

Figure 1. Summary of Objective Evaluation Results.

the MDT members potentially responsible for collection and/or presentation of pertinent information.

Results of the subjective portion of the evaluation instrument (see Figure 2) indicate that 4 out of 10 evaluation respondents rated the piloted SED decision facilitation model as an improvement over previous decision making procedures and practices with regard to "ease of utilization." Eight out of 10 respondents rated the model as an improvement with regard to "within-MDT consistency/reliability," while 6 out of 10 rated it as an improvement with regard to "between-MDT consistency/reliability." Eight out of 10 rated the model as an improvement with regard to model's "level of accountability." Ratings for both, the model "overall" and consideration for the model's "adoption for use system wide," indicated that 8 out of 10 respondents viewed the piloted SED decision facilitation model as an improvement over previous decision making methods and procedures and were in favor of it's adoption for implementation throughout the school system.

Conclusions

Evaluation results suggest that inservice training efforts were successful in improving the indiviudal MDT members' understanding of the critical conceptual components and eligibility criteria found within the SED definition. The decision facilitation worksheet, for those who employed it particularly, provided individual team members and the teams as a whole with a systematic focus for their decision making undertakings. This MDT focus was particularly obvious to the writer during implementation monitoring, and is felt to reflect the systematic nature of the model overall. Initial concerns raised during inservicing with regard to the MDT's

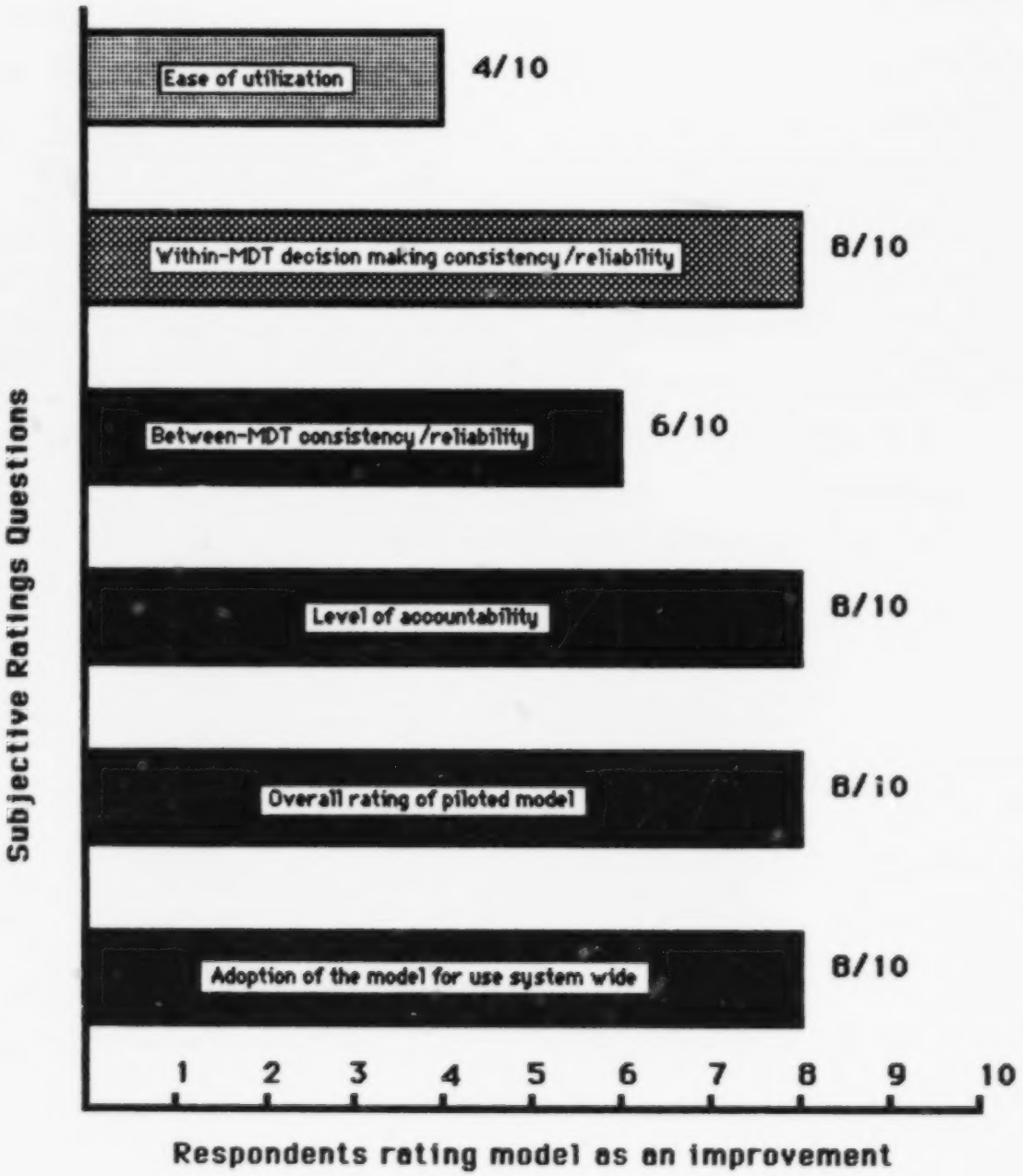

Figure 2. Summary of Subjective Evaluation Results.

responsibility for determining the existence of a "condition" stemmed from the blurring of the boundries between the more traditional medical and educational models. Although not without it's limitations (Gresham, 1985), the psychologist's use of DSM III as a resource in establishing the existence of a condition was readily accepted by other MDT members. However, the use of a more empirically-driven classification system would help to minimize, what Gresham refers to as the "subjective" element to diagnosis.

Evidence from evaluation findings also suggest that MDT members were able to make meaningful connections between pertinent decision making information and the MDT members potentially responsible for gathering and/or presenting the relevant data. The recognition of individual member responsibilities helps to promote increased involvement and commitment to MDT decision making outcomes (Ableson & Woodman, 1983). The discrepancy between required decision data and the post decision data ultimately documented, as identified in the literature by Smith et al. (1984), is minimized when member responsibilities are clarified and the SED decision facilitation worksheet is adhered to by the MDT. Both eligibility criteria and documentation requirements are made explicit in the piloted model.

Individuals who had not utilized the SED decision facilitation model had, in the comments section of the evaluation instrument, expressed concerns regarding the complexity of the model. Lower than expected ratings with regard to "ease of utilization" almost surely reflects these concerns. However, upon closer examination of the evaluation instrument, it was found that individuals who had employed the model consistently rated the model as an improvement with regard to "ease of utilization." It would

appear that practice effects serve to further clarify decision making processes when utilizing the model.

The majority of evaluation respondents rated the piloted model as an improvement over previous procedures with regard to "within-MDT consistency/reliability" and "level of accountability" by a margin of four to one. The more closely split decision with regard to "between-MDT consistency/reliability" (three to two margin in favor of the improvement rating), may reflect the limited exposure of school-based MDT members to other MDTs also utilizing the model. Due to the systematic and highly structured nature of the piloted model, and the results of implementation monitoring, this writer concludes that the actual decision making consistency/reliability between-MDTs would exceed the level indicated in the ratings.

Ratings with regard to the model "overall" and it's possible "adoption for use system wide" support both, the need for SED decision making procedural improvements and, the piloted model's overall effectiveness in meeting the need, at least in part. Findings also suggest that the system wide use of the model would likely be accepted and viewed as an improvement over existing SED decision practices. However, the confidence with which predictions can be based upon collected evaluation data must be tempered by concerns with regard to participant attrition. An informal follow up regarding the attrition factor found that "time constraints" were the most frequently stated reasons for non-compliance during the evaluation phase. It is likely that increased administrative support at the building level would have improved compliance with evaluation requests.

Unanticipated outcomes of the evaluation included numerous requests for inservicing regarding the piloted model by MDTs outside the targeted

group of schools. In one instance, additional inservicing was provided to area-based personnel responsible for making educationally related decisions that are likely to result in more restrictive placements (i.e., self-contained classrooms, special program magnet schools). Because area-based personnel are quite removed from the daily activities of the students for which they are responsible for making educational decisions, the SED decision facilitation model provided them with the format for gathering and documenting eligibility criteria. The systematic orientation of the SED decision facilitation model and the forced minimization of subjective bias, resulted in the model being well recieved by area-based MDT personnel. Other inservice requests could not be accomodated within the short duration of model implementation. As with any unproven procedure, over implementation would have been premature and would defeat the purpose of a "pilot" implementation.

Recomendations

Due to the low incidence of SED within the population overall, piloting efforts could have been aimed at the specific schools and MDTs where program offerings result in a disproportionately high SED student population (i.e., level V magnet schools for SED students). This approach may have increased actual utilization of the model in educational decision making processes. However, the breadth of information gained from the various schools (i.e., grade levels, community factors) and their individual MDTs would be sacrificed for increased "situation specific" model utilization information. The option of choice would depend upon the goal of implementation.

In systems where an individual MDT member is responsible for determining the existence of a SED (i.e., the school psychologist), the piloted model is worth serious consideration as well. While accountability issues shift from the team to the individual, the model continues to provide a systematic vehicle for addressing eligibility criteria. It should be noted however, that the piloted model was developed with the intention of supplementing existing policies and procedures locally. LEA specific, and sometimes arbitrary, decisions regarding operationalization of the SED definition may not be appropriate to other settings, particularly in states not sharing the EHA definition of SED. It is likely however, that adjustments made in situation specific models would not interfere with the soundness of the approach, providing the eligibility criteria (i.e., quantification of "long period of time", or "marked degree") is made explicit and defined operationally.

In order to prevent the significant impact of attrition in an undertaking such as the one presented here, sufficient resources and commitment must be obtained. Many things compete for the time of educators. Increased coordination between building level administrators, MDT chairpersons and the pilot facilitator may pay dividends in the form of summative evaluation information. If the model is implemented on a scale larger than the pilot presented here, it would be wise to include more through implementation monitoring and formative evaluation procedures as well. Consideration should also be given to the use of a parent evaluation/survey instrument so as to assess the impact of procedural changes upon the understandings of parents with regard to the decision making processes.

Finally, it is recommended that efforts be undertaken to improve the relationship between assessment and eligibility procedures and intervention strategies. Without an empirically-driven classification system, the process may formalize rather questionable diagnostic criteria (Russell, 1984). Obviously, the development and use of appropriate intervention strategies is contingent upon an accurate diagnosis.

Dissemination

The final version of this report will be submitted to the Supervisor of Special Education and Psychological Services of the writer's LEA for review and consideration for model implementation system wide (i.e., S-O-P status). If implemented, the model would potentially have impact upon hundreds of educators and students.

A review of the piloted model and the progam's results will be presented at a conference scheduled for the fall of 1987 to colleagues in school psychology within the writer's LEA.

As a committee member of a state level (state department of education and state school psychologists association joint venture) task force examining SED decision making issues, the writer has kept other committee members apprised of LEA implementation efforts. A more formalized opportunity to present the pilot's results will be sought when the next committee meeting's agenda is developed.

The final report will be submitted for consideration to be included in the Office of Education's Educational Resources Information Center (ERIC) database system.

Abstracts will be disseminated to Nova University cluster students and, upon stated interest, summer institute participants.

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APPENDICES

APPENDIX A

LEA GUIDELINES FOR DETERMINING SERIOUS EMOTIONAL DISTURBANCE (SED)

LEA GUIDELINES FOR DETERMINING SERIOUS EMOTIONAL DISTURBANCE

Based on Public Law 94-142 and Maryland State Bylaw 13.04.01, serious emotional disturbance is defined as follows:

... a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

3. Inappropriate types of behavior or feelings under normal circumstances;

4. A general pervasive mood of unhappiness or depression; or

5. a tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

As with all handicapping conditions, the appropriate Admission, Review and Dismissal (ARD) Committee must determine if the condition adversely affects educational performance and whether special education services are therefore required. Educational performance is adversely affected if the ARD Committee can document a severe discrepancy between achievement and intellectual ability using the Procedures for Determining Severe Discrepancy, steps 1-5 (not 6), of the LEA's "Process for Evaluating Children with Learning Disabilities."

In extremely rare cases, the examining psychologist may advise the ARD Committee that using achievement scores is inappropriate. If such advice is well documented and fully explained, the ARD Committee may demonstrate an adverse effect on educational performance over a long period of time by addressing school achievement.

Failing ("unsatisfactory" for primary grades) report card grades and/or a significant reduction in the quality and quantity of class work or assignments occurring for at least the equivalent of one semester for secondary students and one grading period for elementary students must be documented. A written explanation of such a belief must be made by the school ARD team to the Area Coordinator of Special Education. Upon determination by the Area Coordinator that the written explanation is complete and appropriate, the school will schedule a school meeting with the Area Coordinator present where decisions will be made concerning handicapping condition and special education services.

Note: The psychologist/psychiatrist may state that in his/her opinion a student is seriously emotionally disturbed; however, the ARD Committee has responsibility to determine whether that condition adversely affects educational performance and whether special education services are therefore required.

The chairperson of the School ARD and the Area Psychologist should make effort to have the area psychologist present at the ARD meeting where the issue of serious emotional disturbance is being determined for the first time.

APPENDIX B

"GUIDE FOR DISCUSSIONS CONCERNING SERIOUS EMOTIONAL DISTURBANCE"

"GUIDE FOR ARD DISCUSSIONS CONCERNING SERIOUS EMOTIONAL DISTURBANCE"

NAME:

SCHOOL:

DATE:

	I N T E R V I E W S					OBSERVATIONS
	History	Current Facts	Student/Parent Questionnaire	Teacher	Other	
PERCEPTION OF SELF						
PERCEPTIONS OF ENVIRONMENT (Family, School & Others)						
COPING STRATEGIES/ DEFENSES						
THEMES						
STRENGTHS						
WEAKNESSES						
OTHER						

	TEST RESULTS								
	I.Q.	Achievement	Drawings	Sentence Completion	Self Rating	Other Behavior Ratings	TED/TAT	Rorschach	Other Data
PERCEPTION OF SELF									
PERCEPTIONS OF ENVIRONMENT (Family, School & Others)									
COPING STRATEGIES/ DEFENSES									
THEMES									
STRENGTHS									
WEAKNESSES									
OTHER									

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APPENDIX C

SERIOUS EMOTIONAL DISTURBANCE (SED) DECISION FACILITATION WORKSHEET

SERIOUS EMOTIONAL DISTURBANCE (SED) DECISION FACILITATION WORKSHEET

Student Name:_____ **School**:_____

Grade:_____ **Age**:_____ **Date Completed**:_____

Based on Public Law 94-142 and Maryland State Bylaw 13.04.01, serious emotional disturbance (SED) is defined as follows:

... a **condition** exhibiting one or more of the following **characteristics** over a **long period of time** and to **a marked degree**, which **adversely affects** educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. a tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes children who are schizophrenic. The term does not include children who are **socially maladjusted**, unless it is determined that they are seriously emotionally disturbed.

Below you will find an itemized breakdown of the SED definition's critical components, it's specific eligibility criteria, each of which need to be addressed by the multidisciplinary team as part of the SED decision making process. Document specific supporting evidence (i.e., test results and scores, observations, behavior ratings, grades, etc.) under each of the individual factors as appropriate. The "Guide for ARD Discussions Concerning Serious Emotional Disturbance" and "Descriptions of the SED Definition's Critical Components" may prove useful when completing this worksheet.

Is there evidence of a "**condition**"? _____

_____

_____

_____

Which one or more of the "**characteristics**" (listed above 1-5) is being exhibited by the student as a result of the condition? _____

_____

_____

_____

_____

Have these characteristics been exhibited by the student over a "**long period**" of time?_____

_____

_____

_____

Have the characteristics been exhibited to a "**marked degree**"? _____

_____

_____

_____

_____

Does the condition and it's characteristics "**adversely affect**" the student's educational performance? _____

_____

_____

When standardized test results are being used to demonstrate a discrepancy between achievement and ability, complete the following "Eductional Impact" table.

Date Admin.	Test of Intel.	Standard Score	Achievement Test	Standard Score	Difference	2SEm diff*	>or= to 2SEm diff./Check
			Wood.-John. Reading			8**	
			Wood.-John. Math			11**	
			Wood.John. Wr. Lang.			10**	

*Refer to achievement and intelligence test reliability coefficient table

**Only with full scale IQs from WPPSI, WISC-R or WAIS-R

Note: In extremely rare cases the use of achievement test scores may be deemed inappropriate. In these cases, actual school achievement (i.e., report card grades, quality and quantity of class work or assignments) may be used to establish "educational impact", providing documentation is forwarded to the Area Coordinator of Special Education for review and scheduling of a school meeting where final decisions will be made.

Comments_____

_____

_____

_____

Is this student's condition one of "**social maladjustment**"? _____

_____

_____

_____

Are there any other explanations and/or handicapping conditions felt to be equally responsible for the evidence documented within this worksheet? _____

_____

_____

_____

Based upon the above procedures, does this student have a Serious Emotional Disturbance?_____

_____

Signatures of Team Members in Agreement	Position

Note:Team members in disagreement should document their rationale below

_____

_____

_____

APPENDIX D

ELIGIBILITY CRITERIA AND DESCRIPTIONS OF THE CRITICAL CONCEPTUAL COMPONENTS OF THE SED DEFINITION

ELIGIBILITY CRITERA AND DESCRIPTIONS OF THE CRITICAL CONCEPTUAL COMPONENTS OF THE SED DEFINITION

Condition- a pattern of characteristics (i.e., diagnosis) generally recognized as constituting a particular state. Schizophrenia is the only emotional condition specifically referred to in the SED definition. The pattern of characteristics must stem from a condition of an emotional nature. The qualified examiners (psychologists and psychiatrists) are generally responsible for addressing the existence of the "condition." However, the psychologist and the team may utilize the "Guide for ARD Discussions Concerning Serious Emotional Disturbance" as an aid in determining the existence of a condition (i.e., when a psychological report fails to specify a particular condition).

Characteristics- one or more of the SED definition's five (5) descriptive catagories (below) must be exhibited by the student. In addition, the identified characteristic(s) must be in evidence as a result of the "condition." If a student has an identified "condition" but does not exhibit one or more of the characteristics (below), or the student exhibits one or more of the characteristics without having established the existence of a "condition", they do not qualify as SED under the law.

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

3. Inappropriate types of behavior or feelings under normal circumstances;

4. A general pervasive mood of unhappiness or depression; or

5. A tendency to develop physical symptoms or fears associated with personal or school problems.

Long Period- the LEA'S "Guidelines for Determinig SED" specifies the minimum length of time that a student need exhibit one or more of the SED characteristics (above). The "long period" of time criteria will have been met if the characteristic(s) have been exhibited one (1) semester for secondary students and one

(1) grading period for elementary students. Student records (i.e., previous evaluations, observations and/or history) and interview findings (i.e., previous teacher, parents) are useful in providing appropriate supporting evidence.

Marked Degree- one or more of the characteristics must be exhibited in a severe, intense and/or pervasive manner. The characteristic(s), if exhibited to a "marked degree", will be evident and observable to those with whom the student associates. In the absence of readily observable characteristics, the mere representation of the characteristics' severity uncovered in the findings of a specific test (i.e., projective assessment instrument) is insufficient in meeting the "marked degree" criteria. Normed rating scales, specific to the characteristic(s) of concern, offer support to subjective observations.

Adversely Affects- evidence of the condition's and characteristic's negative impact on educational performance must be documented. A discrepancy between the student's actual level of achievement and/or performance and an expected level of functioning (i.e., level of functioning in the absence of the handicapping condition) must be in evidence. When standardized test results are used, the discrepancy between achievement (i.e., Woodcock-Johnson Psycho-Educational Battery) and ability (i.e., Wechsler Intelligence Scale for Children-Revised) may be documented on the "Educational Impact" section of the SED Decision Facilitation Worksheet. If the student's actual level of school performance is being offered as evidence of a performance/ability discrepancy(i.e., in rare cases the examining psychologist may advise that using achievement scores is inappropriate), failing ('unsatisfactory" for primary grades) grades and/or a significant reduction in the quality and quantity of class work or assignments must be documented. If any determination is based primarily on school performance, a written explanation must be made by the team and sent to the Area Coordinator of Special Education. Upon determination by the Area Coordinator that the written explanation is complete and appropriate, the school will schedule a school meeting with the Area Coordinator present where decisions will be made concerning handicapping condition and special education services.

Socially Maladjusted- a student who meets all five (5) of the SED definition's criteria factors (above) is expressly exempted from being identified as SED if the identified "condition" (i.e., diagnosis) constitutes a social maladjustment (i.e., Conduct Disorder, Antisocial Personality Disorder). A socially maladjusted student, who meets the criteria, may be found to be SED if they also suffer from a "condition" (i.e., has an additional diagnosis) other than that of social maladjustment. Refer to psychological evaluations which may contain specific references to a diagnosis and/or condition(s).

Note- The law requires that a student meet all six (6) of the SED definition's criteria factors in order to be considered Seriously Emotionally Disturbed, in the educational sense, and consequently, be eligible for special education services. Eligibility does not necessitate special education placement. Programming and placement decisions should be made by the multidisciplinary team and should assure the student of appropriate services within the "least restrictive environment".

APPENDIX E

INSERVICE OUTLINE: SERIOUS EMOTIONAL DISTURBANCE DECISION FACILITATION PILOT

INSERVICE OUTLINE:
SERIOUS EMOTIONAL DISTURBANCE
DECISION FACILITATION PILOT

I. SED decision making and the cascade of responsibility

A. Overview of the relationship between the federal and state laws and the LEA's interpretation of the SED definition

B. Review the district's existing practices and guidelines for SED decision making

1. Weaknesses and limitations of existing procedures
   a. Consistency and reliability issues
   b. Accountability issues

C. Overview of the practicum process as a practical problem solving undertaking

II. Introduction of the SED decision facilitation model and worksheet

A. Integrating new practices and supplementing the existing

1. MDT member responsibities
   a. Qualified examiner of SED

2. Data collection and presentation
   a. Multidisciplinary
   b. Multi-method

3. Discussion and decision making processes
   a. "Guide for ARD Discussions Concerning SED"

B. Addressing the critical conceptual components of the SED definition

1. Condition
2. Characteristics
3. Long period of time
4. Marked degree
5. Adversely affects educational performance
   a. Achievement/ability discrepancy in standardized test results
   b. Grades, quality and quantity of class work and assignments
6. Social maladjustment

C. Decision making conclusions and documentation

1. Team member participation
   a. Completing and signing the worksheet

III. Project review and evaluation

A. Inservice and implementation phase

B. Evaluation phase
   1. Objective measures
   2. Subjective measures
   3. Comments and suggestions

C. Report and dissemination phase

APPENDIX F

PRACTICUM CALENDAR

PRACTICUM CALENDAR

Submitted proposal to adviser and practicum office for review. Made appropriate revisions.....February 5-23, 1987

Obtained approval and written permission for implementation (action phase) from practicum adviser.....February 25-28, 1987

Obtained final local approval for implementation from the Supervisor of Special Education and Psychological Services and the Area Director (also the practicum verifier).....February 25-28, 1987

Began action phase. Inserviced feeder system multidisciplinary teams (MDTs).....March 2-13, 1987

The MDTs implemented the SED Decision Facilitation Model.....March 2- May 22, 1987

Collected practicum evaluation data. Objectives measurement through MDT assessment.....May 11-22, 1987

Conferenced with adviser to discuss practicum findings and report completion.....May 23-31, 1987

Prepared and submitted report to adviser and program office for review and evaluation.....June 10-24, 1987

Distribute, upon approval, abstracts to cluster and interested summer institute participants. Send two final copies to program office.....July 12-18, 1987

APPENDIX G

SERIOUS EMOTIONAL DISTURBANCE (SED)
DECISION FACILITIATION PILOT EVALUATION FORM

SERIOUS EMOTIONAL DISTURBANCE (SED)
DECISION FACILITATION PILOT EVALUATION FORM

The effectiveness and usefulness of the SED Decision Facilitation pilot will, in part, be determined by the results of participant evaluations.

Below you will find the definition of a serious emotional disturbance based upon PL 94-142 and Maryland Bylaw 13.04.01. **Circle** the six (6) critical conceptual components (i.e., eligibility criteria) of the definition that must be addressed by the multidisciplinary team.

... a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. a tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

****

Match each of the components with it's meaning by **drawing lines** from the circled conceptual components of the SED definition to the appropriate description(s) below. Some may have more than one.

A minimum duration of one academic year
If you have this diagnosis alone you cannot be identified as SED
Signs and symptoms
A particular state or diagnosis
A discrepancy between ability and achievement/performance
Noticable and observable level
One semester for secondary students or one grading period for elementary
Failing report card grades
Schizophrenia is the only one specifically mentioned

List a minimum of eight (8) general areas from which pertinent SED decision making information is obtained. In addition, **list** a minimum of two team members (positions) who are potentially responsible for collecting and/or presenting the information.

AREAS	TEAM MEMBER	TEAM MEMBER

Circle the choice (improvement--remains the same-- no improvement) that, in your opinion, best describes the SED Decision Facilitation pilot as compared with your team's previous SED decision making procedures and practices with regard to:

1. Ease of utilization
   (improvement--remains the same-- no improvement)
2. Level of consistency/reliability of the SED decisions made by your team
   (improvement--remains the same-- no improvement)
3. Level of consistency/reliability of the SED decision made between school's
   (improvement--remains the same-- no improvement)
4. Level of decision accountability
   (improvement--remains the same-- no improvement)
5. General overall rating of the piloted model
   (improvement--remains the same-- no improvement)
6. Adoption of the piloted model for use system wide
   (improvement--remains the same-- no improvement)

Number of times you participated in a multidisciplinary teaming in which the SED Decision Facilitation pilot was utilized. _____

Level of school: High Middle Elementary

COMMENTS_____

_____

_____

Thank you for your cooperation!